NEW HAMPSHIRE INSURANCE DEPARTMENT

169 Manchester Street
Concord, NH 03301-5151

Sylvio L. Dupuis
Insurance Commissioner

BULLETIN

TO: All Insurers Licensed to Sell Accident and Health Insurance, Health Maintenance Organizations and Nonprofit Health Service Corporations

FROM: New Hampshire Insurance Department

DATE: August 30, 1994

RE: **Chapter 294, Laws of 1994 (SB 711)**

The 1994 Session of the New Hampshire General Court resulted in the passage of Chapter 294 , Laws of 1994. This new law represents a significant step toward health care reform and will especially impact individual health insurance and group health insurance sold to small employers with up to 100 employees. Chapter 294 becomes effective January 1, 1995.

As this effective date is not less than five months away, it is vitally important for all health insurers to take immediate steps so that they will be prepared to comply with the new law beginning January 1, 1995. The first step is obviously to become familiar with the new law and how it should be interpreted. The purpose of this Bulletin is to facilitate this process for insurers by addressing the issues that appear to require clarification. Toward that purpose, this Bulletin states how the New Hampshire Insurance Department will interpret the statute's provisions. These interpretations are offered as a guide to health insurers in order to assist them in their efforts to comply with the requirements of Chapter 294.

1. Application

The statute indicates that Chapter 294 applies to "small employers" employing "one and up to 100 employees, including owners and self-employed persons." Thus, the owner of a business or organization or a self-employed person would be a "small employer" for purposes of Chapter 294. When determining eligibility for group insurance opposed to individual insurance insurers may require owners and self-employed persons to be actively engaged in their business or organization. At the upper end, "small employers" with 100 or fewer employees will be subject to Chapter 294. Employers with 101 or more employees will not be subject to Chapter 294. The applicability of Chapter 294 to a particular group is to be based on the number of employees rather than the number of employees enrolled in the small employer's plan.

2. Part-time Employees

A question has been raised as to whether or not part-time employees are to be counted as employees. Our position is that part-time employees are to be counted if they are eligible for the insurance. If only full-time employees are eligible for the insurance, part-time employees are not to be

counted. Please recall that RSA 415:18 I(q) allows the employer to determine if part-time employees are to be eligible. RSA 415:18 I (q) also defines a part-time employee.

3. "Small Employers" with A.S.O. Plans

Self-funded "small employers," i.e. small employers with fewer than 101 employees who sponsor self-insured, single employer employee benefit plans serviced by an insurer or third party administrator under an Administrative Services Only contract are not subject to Chapter 294. The Insurance Department recognizes that the "pre-emption clause" of ERISA precludes state regulation of such plans. A minimum premium plan is to be considered a fully insured plan.

4. Short Term Medical Plans

Short term or temporary medical policies written as individual insurance are not affected by or subject to Chapter 294. However, a short term medical plan is to be considered "previous health insurance" for the purposes of RSA 420-G:4 II(b). Also, Chapter 294 does not apply to stand alone policies providing long term care benefits, nursing home benefits, home care benefits, dental benefits, vision care benefits, hospital or surgical indemnity benefits with specific dollar amounts, accident only indemnity benefits, accidental death and dismemberment benefits, prescription drug benefits, disability income benefits, specified disease benefits or to policies providing any combination of the aforementioned benefits.

5. "Qualified Association Trust or Other Entity"

The statutory definition of "qualified association trust or other entity" indicates that such a trust or other entity would provide a health benefit plan covering at least 1,000 employees and/or dependents of association members. The Insurance Department will interpret this as requiring that at least 1,000 employees and/or the dependents of association members who are provided a health benefit plan by the trust be residents of New Hampshire. Any such association should also have been established and maintained for a primary purpose other than the provision of health insurance plans. The offering of incidental or miscellaneous benefits in conjunction with the offering of a health insurance plan shall not be sufficient to show that an association was established or maintained for purposes other than the provision of health insurance. Further, as to the requirement that such associations conduct regular meetings designed to further the interests of its members, the Insurance Department shall consider an association to satisfy this requirement if such meetings are held at a preannounced date and time within the State of New Hampshire and if such meetings are open to participation by association members. To be considered a "qualified association trust or other entity," the trust or other entity must satisfy all criteria stated in the statutory definition. All such entities shall comply with all requirements stated under RSA 420-G:5.

6. Pre-existing Conditions Provision Upon Open Enrollment

With respect to persons who enroll in a "small employer" or individual health insurance plan upon open enrollment, the pre-existing condition waiting period will be as specified by RSA 420-G:4 II(a)(1) or (2). Except with respect to groups with more than 100 employees, the 18 month provision found under RSA 415:18 XII(c) has been superseded by Chapter 294. Note RSA 420-G:3 III. Also, the pre-existing condition waiting period of RSA 420-G:4 II(a) will apply to persons who voluntarily disenroll from a health benefit plan and who subsequently reenroll during an open enrollment.

7. Notification of Open Enrollment

The insurance carrier shall notify each small employer directly of the period of time designated for the small employer's annual open enrollment period. Notification through an agent or broker is

considered indirect notification and shall not be acceptable as direct notification. Carriers shall provide notice of the designated open enrollment period to small employers at least 30 days prior to the date the open enrollment period begins.

8. In-Force Policies

Policies that are in-force prior to January 1, 1995, whether they be individual policies or group policies, shall comply with RSA 420-G:4 I(a) as of the policy's anniversary date or renewal date whichever occurs first on or after January 1, 1995. Carriers shall comply with all requirements of RSA 420-G:4 I(b) and (c) beginning on January 1, 1995, with respect to both old and new business.

9. Membership Types

RSA 420-G:4 I(a)(1) indicates a three tier grouping of membership types for which different community rated premiums may be computed. The use of the three tier grouping shown is intended as an example and is not intended to preclude grouping of insureds by other membership types, e.g. two tier, four tier or other commonly used groupings, provided that any tier groupings used do not violate any other provisions of RSA 420-G.

10. Application Forms

Application or enrollment forms for health insurance plans subject to RSA 420-G used by carriers on or after January 1, 1995, shall not contain any questions relating to the applicant's health or medical history, avocations, hobbies or health status. If a small employer or individual makes a concurrent application for group or individual life insurance, the carrier shall use a separate application for life insurance when the life insurance is subject to underwriting. The separate life insurance application may contain questions relating to the applicant's health or medical history, avocations, hobbies or health status. A carrier may underwrite or refuse a life insurance application from an individual or group. However, under no circumstances shall the carrier's decision with respect to any application for the life insurance have any effect on the guaranteed issue status of any group or individual health insurance application. Under such circumstances, it is obvious that the issuance of health insurance to a small employer or individual shall never be contingent on the concurrent issue of group or individual life insurance. A carrier shall also use a separate application if a small employer or individual makes a concurrent application for a group accident and health insurance coverage that is not subject to RSA 420-G. Such an application may contain underwriting questions.

11. Age Brackets

If a carrier modifies the average premium for age, it may do so only by using the age brackets specified under RSA 420-G:4 I(a)(3). Premium rates for the 65+ age bracket may be differentiated to reflect the fact that some persons in the age bracket will have Medicare as their primary carrier while, for others, the employer's plan will be the primary carrier. A carrier, if it wishes, may use premium rates that do not modify the average premium for age.

12. Availability of Plans

On or after January 1, 1995, any individual or small employer, whether insured or uninsured, may apply for and be accepted for all benefit plans subject to RSA 420-G sold by any carrier in the individual and small group market. No carrier shall restrict the availability of any benefit plan or options it sells in the individual and small group market. A carrier may deny renewal of a small employer plan based on any one of the reasons stated under RSA 420-G:4 I(c)(4). However, any small employer denied renewal may

apply for any one of the benefit plans offered by any other carrier participating in the small employer market and any such small employer shall be guaranteed acceptance by the carrier to whom application is made.

13. Exclusion Riders/Elimination Endorsements

Exclusion riders or elimination endorsements that are a part of any individual health insurance policy issued prior to January 1, 1995, shall be removed from all policies that are subject to Chapter 294 upon the first anniversary or renewal date to occur on or after January 1, 1995. Carriers should notify the plan holder of the removal of such riders or endorsements. NOTE: This Bulletin assumes that any exclusion riders or elimination endorsements that were ever part of any group health insurance policy or certificate would have been removed during 1993 pursuant to Chapter 222, Laws of 1992.

14. Existing Business

The Insurance Department is aware that some health insurers will wish to cease marketing new health insurance plans beginning January 1, 1995, but that such insurers also desire to retain and service existing health insurance plans that were effective prior to January 1, 1995. It is the Insurance Department's view that such action is compatible with Chapter 294 and health insurers may proceed in this manner if they so desire. However, any existing business that is continued shall be brought into compliance with Chapter 294 upon the first anniversary or renewal date to occur on or after January 1, 1995. For example, the renewal rates would be based on a community rating basis and any existing exclusion riders would be removed. Any insurer that chooses to cease selling plans subject to RSA 420-G shall have its license restricted.

15. Rates and Rate Filings

a. As we interpret Chapter 294, it allows insurers to maintain a distinction between individual health insurance plans and small employer group health insurance plans. An insurer may likewise maintain separate community rates for its individual health insurance plans and separate community rates for its small employer group health insurance plans. A carrier that markets small employer group health insurance plans will not be required by Chapter 294 to also market individual health insurance plans. Nor does Chapter 294 require an insurer offering individual health insurance plans to also offer group health insurance plans. Neither will a group health insurance carrier that issues only conversion policies be required by Chapter 294 to issue other individual health insurance plans.

b. All rate filings, whether for individual or small employer group insurance shall include an actuarial memorandum. The actuarial memorandum shall describe how the rates were developed and shall include the following information:

(1) A table of expected claim costs, based on the carriers experience in this State to the extent such experience is credible. The experience on all policy forms, which are subject to this Chapter shall be aggregated for this purpose. For example, if a rate filing is made for an individual major medical policy, rates for the policy are to be based on the aggregate experience of all in-force individual major medical policies of the insurer. If a carrier's business in this State is not credible, then the carrier may use the experience of New Hampshire and a contiguous state or states, New England experience or, if none of the foregoing are credible, national experience may be used. Alternatively,

the carrier may use published data. The assumptions and methods used to develop the experience tables shall be clearly delineated.

(2) A list of all policy forms whose experience was captured for estimating claim costs and/or are subject to Chapter 294. This list shall identify each form as either active or inactive, and include the date the form was first approved for use in New Hampshire, and the date it was withdrawn.

(3) The expected distribution of business to be sold, as well as the distribution of the carrier's in-force should be specified. The average premium rate, based on these distributions, should be specified.

(4) Persistency and expense assumptions, as well as any other relevant information which the company feels is appropriate.

(5) All rates, or calculation worksheets enabling the Insurance Department to determine every possible rate, shall be included in the memorandum.

(6) The future anticipated loss ratio shall be based on expected sales over a 12 month period and the carrier's in-force. The anticipated loss ratio shall be calculated as the expected incurred claims divided by the expected earned premium.

(7) The expected timing and magnitude of future rate changes.

(8) The definition of the pure premium rate may include adjustment factors representative of variations in plan design. Such factors shall be actuarially justified and shall be included in the memorandum. Such factors shall not be bundled with the experience tables required by item (1) above; but rather, such factors shall be shown in a separately identified table. The methods and assumptions used to derive such factors shall be clearly delineated.

(9) The current rates, which have been previously approved.

(10) Any changes in the assumptions made since the last approved rate revision, or since the approved initial rate filing if there are no previous rate revisions.

(11) A complete history of all previously approved rate changes, including the date the increase was approved and the percentage change in the rates.

(12) The loss ratios based on recent historical experience shall be shown.

c. During the transition period, January 1, 1995 through December 31, 1999, renewing group policyholders and renewing policyholders of individual policies shall not have their rate increased by more than 25% per year due to the adoption of Chapter 294. It is recommended that carriers use the following method to determine the final rate charged to renewing policyholders:

(1) Calculate rates and rate table, without regard to RSA 420-G:4 I(a)(4), but complying with all other requirements of RSA 420-G. If the carrier is seeking a rate revision due to changes in cost or utilization trends, then the carrier should calculate two sets of rates, as follows:

(a) The first set shall be based on expected costs before considering the revised trends.

(b) The second set shall be based on expected costs after considering the revised trends.

(2) The carrier should then calculate the percentage change a policyholder would realize if the policyholder's rate had been based on the first set of rates and if the policyholder's new rate was going to be based on the second set of rates.

(3) The renewing policyholder's rate shall be the lessor of:

(a) One plus the factor calculated in item (2) above plus .25 times the rate charged the renewing policyholder in the prior year.
(b) The community rate calculated based on the second set of rate tables above.

(4) The newly issued policyholder's rate shall be based solely on the derived community rates in 1.(b) above.

d. List billing, the practice of charging each employee of a small employer a premium rate based on his or her age bracket, will be permitted if the small employer has less than 10 employees enrolled in the employer's health insurance plan.

e. The child rate under either a child only policy or a policy covering either one or two parents shall correspond to the rate for the 0-24 age bracket.

f. The actuarial certification that is to be filed on each March 1, pursuant to RSA 420-G:7 II, shall include the following information:

(1) A description of the certifying actuary's qualifications to write the certification.
Definitions of qualifying actuaries are included in NHCAR Part Ins 900;

(2) A description of the certifying actuary's personal involvement in pricing, marketing and underwriting; and

(3) A specification by the certifying actuary of those areas where he/she had to rely
on others. It is not appropriate for an actuary to sign a certification just based on a general knowledge of the carrier's practices without documenting the basis for such an opinion.

g. Effective January 1, 1995, all carriers shall submit rates suitable for electronic data processing. At present, this will require each carrier to submit rates on a 3.5" floppy diskette with a density of DS/HD or DD. The technical requirements applicable to such floppy diskette rate filings are shown on "Attachment A." Please note that this floppy diskette rate filing requirement is in addition to the rate filing that is to be submitted in the traditional paper format. Following approval or disapproval, the diskette will be returned to the carrier. Accordingly, we remind carriers of the requirement specified in NHCAR Part Ins 401.02(a)(3).

16. Electronic Submission of Data to Public Health Services

Pursuant to RSA 420-G:4 V, all carriers shall electronically provide claims data to the Division of Public Health Services, Department of Health and Human Services. The Division is working closely with the Insurance Department. An administrative rule, which will identify the specific claims data to be requested, will be forthcoming. In general, the Division anticipates collecting individual membership and encounter data as well as aggregate claims data. Carriers with concerns or questions relative to such data requirements are invited to communicate their questions or concerns to the Insurance Department.

17. Noncitizens

A carrier shall not deny coverage to any applicant who is a New Hampshire resident on the basis that the applicant does not hold United States citizenship. The "guaranteed acceptance" requirement of RSA 420-G applies to both citizens and noncitizens who are New Hampshire residents.

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Carriers with additional questions, i.e. questions not covered by this Bulletin or questions not sufficiently clarified by this Bulletin are advised to contact **Robert C. Warren, Jr., Director, Life, Accident and Health Insurance Division**, or should the questions involve a rating issue, **David C. Sky, ASA, MAA, Life and Health Actuary**. Both can be reached at **603-271-2261 or by fax 603-271-1406.**

Finally, carriers are urged to submit all forms and rates necessary to them in order to comply with Chapter 294 as of January 1, 1995, as soon as they possibly can. The Insurance Department cannot guarantee that late submissions will be approved prior to January 1, 1995.

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The following data shall be included in ACSII format:

Field Name	Start Byte	End Byte	Length	Format	Default
Company Name	1	50	50	Text	
NAIC Company Code	51	55	5	xxxxx	
Form Number	56	70	15	Text	
Original Form Approval Date	71	78	8	mm/dd/yy	
Coverage Code (See Table)	79	82	4	Text	
Renewability Code (See Table)	83	84	2	Text	
Deductible	85	89	6	xxxxxx	
Out-of-Pocket	91	96	6	xxxxxx	
Coinsurance Percent	97	100	4	x.xx	
Calendar Year Maximum	101	109	9	xxxxxxxxx	
Lifetime Maximum	110	118	9	xxxxxxxxx	
Underwriting Class (LTD only)	119	120	2	Text	NA
Age Type (See Table	121	121	1	Text	
Rate Type (See Table)	122	122	1	Text	
Plan Type (See Table)	123	123	1	Text	
Conversion Indicator	124	124	1	Y/N	
Premium Rate (0-24) or Age 15	125	133	9	xxxxxx.xx	
Premium Rate (25-34) or Age 30	134	142	9	xxxxxx.xx	
Premium Rate (35-44) or Age 40	143	151	9	xxxxxx.xx	
Premium Rate (45-54) or Age 50	152	160	9	xxxxxx.xx	
Premium Rate (55-64) or Age 60	161	169	9	xxxxxx.xx	
Premium Rate (65+) or Age 65	170	178	9	xxxxxx.xx	
Effective Date for Rates	179	186	8	mm/dd/yy	
Premium Mode (See Table)	187	187	1	Text	

Coverage Code Table

Code	Code Description
MMED	Major Medical
STHP	Short Term Hospital Coverage
STMD	Short Term Medical/Surgical Coverage
STHM	Short Term Hospital and Medical/Surgical Coverage
DIST	Short Term Disability Income Insurance
ACC	Accident Only Coverage
SPDC	Specified Disease Policy - Cancer
LTCF	Long Term Care - Facility Coverage Only
LTCH	Long Term Care - Home Coverage Only
LTCB	Long Term Care - Both Facility and Home Coverage
HSPI	Hospital Indemnity
HSPE	Hospital Expense
MEDE	Medical/Surgical Expense
HMDE	Hospital/Medical/Surgical Expense
DILT	Long Term Disability Income Insurance
DIOH	Overhead Expense Disability Income
DIBO	Buy-out Disability Income Insurance
LTOT	Other Limited Type of Benefits
SPDO	Specified Disease Policy - Other

Renewability Code Table

Renewability Code	Renewability Description
GR	Guaranteed Renewable
CR	Conditionally Renewable
OR	Optionally Renewable
NC	Non-Cancelable

Age Type Table

Age Type Code	Age Type Description
A	Attained Age
1	Issue Age

Rate Type Table

Rate Type Code	Rate Type Description
M	One Person - Male Rates
W	One Person - Female Rates
U	One Person - Unisex Rates
2	Two Person Rates
F	Family Rates

Plan Type Table

Plan Type Code	Plan Type Description
G	Group Plan
1	Individual Plan

Premium Mode Table

Premium Mode Code	Premium Mode Description
A	Annual
S	Semi-Annual
Q	Quarterly
M	Monthly